

MDR Tracking Number: M5-04-0380-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-03-03. Per Rule 133.308(e)(1) dates of service 06-28-02 through 10-01-02 were not timely filed.

The IRO reviewed hot or cold pack therapy, therapeutic exercises, office visit/outpatient, therapeutic activities, office visits with manipulation, electrical stimulation, vasopneumatic device therapy, sensory nerve conduction testing, neuromuscular re-education, myofascial release and phonophoresis rendered from 10-04-02 through 07-10-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-13-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
10-4-02 through 3-14-03 (16 DOS)	99211	\$480.00 (1 unit @ \$30.00 X 16 DOS)	\$0.00	No EOB	\$18.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for 15 DOS 10-4-02 through 12-19-02. No information was submitted for DOS 3-14-03. Reimbursement recommended in the amount of \$18.00 X 15 DOS = \$270.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
10-30-02 through 4-25-03 (8 DOS)	97530	\$1,135.00 (4 units @ \$35.00 per unit DOS 10-30-02, 1 unit @ \$35.00 DOS 11-22-02, 4 units @ \$40.00 DOS 12-16-02 through 4-25-03 total of 29 units)	\$0.00	No EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for DOS 10-30-02 through 1-16-03. Requestor did not submit relevant information to support delivery of service for DOS 3-14-03 through 4-25-03. Reimbursement recommended in the amount of \$35.00 X 29 units = \$1,015.00
10-30-02 through 4-25-03 (7 DOS)	97110	\$1,100.00 (\$4 units @ \$35.00 per unit DOS 10-30-02, 4 units @ \$40.00 per unit DOS 12-16-02 through 4-25-03 total of 28 units)	\$0.00	No EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
11-20-02	95904	\$270.00 (3 units @ \$90.00 per unit)	\$0.00	N	\$64.00	96 MFG GENERAL INSTRUCTIONS GR (I)(C)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
11-26-02 through 4-25-03 (7 DOS)	99213-MP	\$385.00 (1 unit @ \$55.00 X 7 DOS)	\$0.00	No EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for 4 DOS 11-26-02 through 3-31-03. Requestor did not submit relevant information to support delivery of

							service for 4 DOS 4-22-03 through 4-25-03. Reimbursement recommended in the amount of \$48.00 X 4 DOS = \$192.00
11-26-02 through 12-5-02 (2 DOS)	97032	\$120.00 (2 units @ \$60.00 X 2 DOS total of 4 units)	\$0.00	No EOB	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$22.00 X 4 units = \$88.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
11-26-02 through 12-5-02 (2 DOS)	97016	\$60.00 (1 unit @ \$30.00 X 2 DOS)	\$0.00	No EOB	\$24.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$24.00 X 2 DOS = \$48.00
11-26-02 through 4-25-03 (2 DOS)	97250	\$86.00 (1 unit @ \$43.00 X 2 DOS)	\$0.00	No EOB	\$24.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for DOS 11-26-02. Requestor did not submit relevant information to support delivery of service for DOS 4-25-03. Reimbursement recommended in the amount of \$24.00 X 1 DOS = \$24.00
12-5-02 through 3-25-03 (2 DOS)	99214	\$160.00 (1 unit @ \$80.00 X 2 DOS)	\$0.00	No EOB	\$71.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$71.00 X 2 DOS = \$142.00
3-18-03	97139-PH	\$50.00 (1 unit)	\$0.00	No EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet documentation criteria. Reimbursement

							recommended in the amount of \$50.00
3-18-03	97139-I	\$40.00 (1 unit)	\$0.00	No EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$40.00
3-16-03	99455	\$300.00 (1 unit)	\$0.00	D	DOP	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
4-25-03	97112	\$35.00 (1 unit)	\$0.00	No EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$4,221.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$1,869.00

**RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 16<sup>th</sup> day of April 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh

### ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-04-02 through 07-10-03 in this dispute.

This Order is hereby issued this 16<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division  
RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

**Amended Letter**

**Note:** Decision

January 8, 2004

MDR Tracking #: M5-04-0380-01  
IRO Certificate #: IRO 4326

The \_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. \_\_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient was injured on \_\_\_\_ when he slipped on a pool liner and fell. He reported low back pain and numbness and tingling in his left leg. A lumbar MRI dated 10/19/00 revealed disc degeneration, neuroforaminal stenosis, and herniation at L3-4 for which he underwent a laminectomy on 01/09/02.

Requested Service(s)

Therapeutic exercises, therapeutic activities, office visit with manipulation, electrical stimulation, vasopneumatic device therapy, sensory nerve conduction testing, neuromuscular re-education, myofascial release, phonophoresis, office visit/outpatient and hot/cold pack therapy from 10/04/02 through 07/10/03

Decision

It is determined that the therapeutic exercises, therapeutic activities, office visit with manipulation, electrical stimulation, vasopneumatic device therapy, sensory nerve conduction testing, neuromuscular re-education, myofascial release, phonophoresis, office visit/outpatient and hot/cold

pack therapy from 10/04/02 through 07/10/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Post surgically, the patient began rehabilitation exercise and strengthening in May of 2002. Electromyography and nerve velocity conduction studies performed were essentially normal. A functional capacity evaluation (FCE) dated 10/31/02 revealed the patient was capable of returning to work in a medium job classification. He was seen by another designated doctor on 12/11/02 and found to be at maximum medical improvement (MMI) with a 5% impairment rating. There appeared to be a discrepancy with the designated doctor's report and evaluation and his decision was disagreed with by the treating doctor. The treating doctor requested another doctor, acting in his place, to perform an evaluation. This was done on 03/26/03 and the patient was placed at statutory MMI on 09/19/02 with a 20% impairment rating. The treating doctor agreed with this report.

Regardless as to the MMI date and actual impairment rating, the denied services listed were excessive. The records indicate this patient had received chiropractic care with the inclusion of passive and active therapies since 03/04/02. Chiropractic guidelines usually allow for two to six weeks of passive therapies with progression into active therapy. Active therapy is normally allowed for two to four months after which the patient is released to a home exercise program. Ongoing continual supervised one-on-one therapy is not clinically warranted. Therefore, it is determined that the therapeutic exercises, therapeutic activities, office visit with manipulation, electrical stimulation, vasopneumatic device therapy, sensory nerve conduction testing, neuromuscular re-education, myofascial release, phonophoresis, office visit/outpatient and hot/cold pack therapy from 10/04/02 through 07/10/03 were not medically necessary.

Sincerely,